**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**
**IMMUNIZATION PROGRAM**

For Healthier Lives

Immunize

# Provider Enrollment Form

## For Adult-Only Practices

**2008**

**DO NOT USE THIS FORM IF YOU SEE PATIENTS UNDER 19 YEARS OLD**

**Please type or print *neatly***

**Vaccine Provider Site Number:** ___ ___ ___ ___ ___

**Name of Facility or Practice:** _____

**Mailing Address:** _____

_____

_____

City State Zip

**Shipping Address:** (P.O. Boxes are not acceptable shipping addresses)

_____

_____

City State Zip

**Telephone:** _____

**Fax:** _____

**Contact (name):** _____

**E-mail address:** _____

If possible, please list a general e-mail address for your facility. Personal e-mail addresses are acceptable if your facility does not have a general e-mail.

**Hours of Operation**

Monday: Thursday:

Tuesday: Friday:

Wednesday:

**Shipping Contact:** _____

**Medical Director's Name:** _____

**Medicare Provider Number*:** _____

*Only Long Term Care Facilities need to provide

**Practice Type** (please check only one)

- ❑ Board of Health (01)
- ❑ VNA (08)
- ❑ Home Health Agency (25)
- ❑ Community Health Center (03)
- ❑ Multi-Specialty Center (27)
- ❑ Public Hospital (02)
- ❑ Private Hospital (12)
- ❑ Correctional Facility (06)
- ❑ Public School (04)
- ❑ Private School (19)
- ❑ Public College (05)
- ❑ Private College (20)
- ❑ Nursing/Rest Home/LTCF (22)
- ❑ Assisted Living/Adult Day Care (26)
- ❑ Other State Agency (07)
- ❑ Other (Specify) (09 pub/23 priv)

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- ❑ Pediatric Practice (15)
- ❑ Family Practice (14)
- ❑ Council On Aging (10)
- ❑ Internal Medicine (17)
- ❑ OB/GYN (18)
- ❑ Walk-In (21)
- ❑ Specialty Practice (16)
- ❑ Employee Health (24)

***To receive vaccine provided by the Massachusetts Department of Public Health Immunization Program, I, on behalf of myself and any and all practitioners associated with his medical office, group practice, HMO, health department, hospital, clinic, vaccine distributor, or other entity of which I am the medical director or equivalent, agree to the following:***

1. **I will comply with the federal and state requirements for vaccine ordering and management as outlined in the enclosed *Guidelines for Compliance with Federal Vaccine Administration Requirements* .**
2. I will comply with the appropriate immunization schedule, dosage, and contraindications that are established by the Department of Health and Human Services' Advisory Committee on Immunization Practices (ACIP), unless (a) in making a medical judgement in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or (b) the particular requirement is not in compliance with Massachusetts law, including laws relating to religious or other exemptions[1].
3. I will provide vaccine information materials and maintain records in accordance with the National Childhood Vaccine Injury Act.
4. I will not impose a charge for the cost of the vaccine.
5. I will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee of $15.78 per dose established by DHHS. Administration fees may be billed to third party payers if they cover such costs.
6. I will not deny administration of federally procured vaccine to any patient due to the individual's inability to pay an administration fee.
7. I will provide, with this agreement, a list of all physicians, physician assistants, nurse practitioners and nurse-midwives at this facility who prescribe vaccines.
8. I or the Commonwealth may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

***Medical Director statement: I certify that I have read and agree to the requirements listed above pertaining to participation in the Massachusetts Immunization Program.***

**Medical Director's signature** _____

**Vaccine Provider Site Number** ____ ____ ____ ____ ____ **Date** _____

This record is to be submitted to and kept on file at the Massachusetts Department of Public Health and must be updated annually.

1 The ACIP immunization schedule is compatible with the AAP recommendations.

# Provider List

List below all physicians, physician assistants, nurse practitioners
and nurse-midwives who prescribe vaccines in your practice.

| **Name and Title** (MD,DO,PA,NP,CNM) | **Name and Title** |
|---|---|
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Attach additional sheets if necessary.